Exhibit A Part 2

Over-the-counter products are not covered unless specifically included, such as insulin.

H. Definitions

1) All Company-Sponsored Medical Plans

Alcohol or Other Drug Dependency Treatment Center

A facility which provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician and also:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral, and
- Accredited as such a facility by the Joint Commission on Accreditation of Hospitals, and
- Licensed, certified, or approved as an alcohol or other drug dependency treatment center by any state agency having legal authority to so license, certify or approve.

Ambulatory Surgical Center

Any public or private establishment which:

- Has an organized staff of medical physicians, and
- Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, and
- Has continuous physician services and registered professional nursing services whenever a patient is in the facility, and
- Does not provide services or other accommodations for patients to stay overnight, and
- Is certified by the claims administrator.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Convalescent Facility

An institution (or distinct part of an institution) which:

- Is primarily engaged in and licensed to provide on the premises and for compensation from its patients skilled nursing services and physical rehabilitation services to convalescing patients, and
- Provides these services under the full-time supervision of an M.D., D.O. or R.N., and
- Maintains a complete medical record on each patient, and
- Is not other than incidentally a place for rest, for custodial care, for educational care, for the aged, drug addicts, alcoholics, or individuals who are mentally retarded or have mental disorders, and
- Has a written personal treatment plan for each patient which is prescribed and supervised by an M.D. or D.O., includes a diagnostic assessment of the patient and a description of the treatment to be rendered, and provides for follow-up assessments by or under the direction of the supervising M.D. or D. O., and
- Provides an ongoing quality assurance program which includes reviews by M.D.'s or D.O.'s who do not own or direct the facility.
- A convalescent facility will be treated the same as a hospital as the term used to determine benefits for physician services.

Cosmetic Surgery — Plastic surgery or reconstructive surgery which improves, alters or enhances appearance, except to the extent needed to:

- Improve the function of a part of the body (other than a tooth or structure that supports the teeth) that is malformed as the result of a severe birth defect (including harelip or webbed fingers or toes) or as a direct result of a disease or surgery performed to treat a disease or injury, or
- Repair an injury, which occurs while the person is covered by the Plan, in the calendar year of the accident which causes the injury or in the next calendar year.

Covered Expense — A medical expense incurred under the direction of a physician, which is necessary for the treatment of an injury or sickness, not specifically excluded or otherwise limited under the Plan, not in excess of specified maximums, and is reasonable. This includes expenses for designated preventive diagnostic testing and designated immunizations and vaccinations.

Custodial Care — Routine services or supplies, including room and board and other institutional services, furnished to assist in daily living. Room and board will not be considered custodial care when combined with skilled nursing services and other necessary therapeutic services and supplies in accordance with generally accepted medical standards.
Such services and supplies must be provided in an institution which is approved by the claims administrator. Any medical treatment program which includes custodial care elements must be reasonably expected to substantially improve the covered person's medical condition in order to be covered.

Dependent — Eligible dependents include your:

- Spouse, as defined by the laws of your state
- Unmarried children under age 19, including
  - Natural children
  - Legally adopted children
  - Stepchildren living with you, and
  - Children in your legal custody by court decree, who permanently live in your household, depend primarily on you for financial support, and live with you in a normal parent-child relationship

- *For employees hired on or after 2/5/95;* Unmarried dependent children who are at least age 19 but under age 25 who
  - Have the same permanent, legal residence as you, and
  - Are primarily dependent upon you for maintenance and financial support, and
  - Are in regular, full-time attendance at an accredited secondary school, college, or university.
- *For employees hired prior to 2/5/95;* Unmarried dependent children who are at least age 19 but under age 25 who
  - are not in the military or similar forces of any country
  - are not employed full time
  - are not residing outside the US and Canada, and
  - are principally dependent on the employee for maintenance and support.
- Unmarried dependent children who are mentally or physically disabled.

The plan administrator establishes whether a student is attending an accredited school using the reference book, *Accredited Institutions of Postsecondery Education*, published by the American Council on Education.

No other dependents are eligible for coverage, even if they live with the employee and depend on them for support.

Eligible dependents do not include:

- Your (or your spouse's) parents or grandparents, even if living with you and dependent upon you for support
- Your married children
- Your sister or brother
- Your grandchildren, unless they become your legal dependents by legal adoption or guardianship
- Your brother-in-law or sister-in-law
- Your stepchildren who do not live with you, unless you or your spouse are required to provide them with coverage under the terms of a divorce decree, or
- Your aunts, uncles or cousins.
- An eligible dependent child cannot be actively serving in the armed forces of any country.

Disabled Child Your unmarried, disabled child is eligible for continued medical coverage if the child is:

- Physically or mentally disabled
- Incapable of self-support upon reaching age 19 or 25 – when eligibility would otherwise end
- Unmarried, and
- Claimed as a dependent on your federal income tax return.

If you wish to continue coverage for a disabled child:
You must provide proof of the child's disability that is acceptable to the claims administrator within 30 days after your child reaches the age (19 or 25) when eligibility would otherwise end.

DRG Diagnostic Related Groups. Classifications to group inpatient cases by principal diagnosis and other relevant factors. The "DRG Amount" is a predetermined charge for each DRG as determined by applicable law (or regulations) or by the Claims Administrator.

Home Health Care A program for continued care and treatment of an individual, normally within seven days following hospitalization for the same or related conditions for which hospitalized. The necessity of the program must be certified by the attending physician and approved by the claims administrator. Services rendered under the program are skilled nursing care, home health services, paraprofessional nursing care, therapeutic services (physical or speech therapy), medical supplies, drugs, and laboratory and x-ray services. The care must be provided by a registered nurse or a state-certified home health care aide under a registered nurse's supervision. The care will not be covered if:

- Not included in a claims administrator approved home health care program,
- Provided by a person who ordinarily resides in your home, or by an immediate family member,
- Provided by a social worker, or
- Consists of transportation services.

Hospice A centrally administered program of palliative and supportive services which provides physical, psychological, social and spiritual care for dying persons (who have six months or less to live as diagnosed and certified by the attending physician) and their families. Services are provided by a physician-supervised interdisciplinary team of professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock on-call basis. Bereavement services are available to the family. Benefit approval for a hospice program of care is based on patient and family need.

Hospital An institution which:

- Maintains permanent and full-time facilities for bed care of resident patients, and
- Has a physician in regular, full-time attendance, and
- Continuously provides 24-hour-a-day nursing service by registered nurses, and

- Primarily engages in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics or a place for drug addicts, and
- Operates lawfully in the jurisdiction in which it is located.

Medicare Allowable Charge — The charge which Medicare considers to be an appropriate reimbursement for charges made by providers other than hospitals.

Necessary — A service or supply is Necessary if it is for the diagnosis, care or treatment of a physical or mental condition and widely accepted professionally in the U.S. as effective, appropriate, and essential, based upon recognized standards of the health care specialty involved.
The Plan will not consider Necessary:

- Services rendered by a health care provider that do not require the technical skills of the provider, or
- Services and supplies furnished mainly for personal comfort or convenience of the covered person, any one who cares for the covered person, or any member of the covered person's family, or
- Services and supplies furnished because the covered person is hospitalized on a day when he or she could be diagnosed or treated while not hospitalized, or
- The part of the cost that exceeds that of any other service or supply which would be sufficient to diagnose and treat the physical or mental condition.

Outpatient Preadmission Test — A test performed in anticipation of hospital confinement if:

- The test is related to the problem for which hospitalization is required
- The test has been ordered by a physician after a condition requiring the confinement has been diagnosed and the hospital admission has been requested, and
- The test is done within seven days prior to the hospital admission.

Physician

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Chiropractic (D.C.)
- Doctor of Podiatry (D.P.M. or D.S.C.)
- Doctor of Dentistry (D.D.S. or D.M.D.)
- Doctor of Optometry (O.D.)

A physician for purposes of mental health and substance abuse treatment includes psychiatrist, psychoanalyst, psychologist, or other physician specializing in the treatment of substance abuse or mental health disorders. The physician must be licensed by the State in which the service is provided.

The physician must be licensed to perform a particular service which is covered by the Plan. The physician cannot be a member of a covered person's immediate family.

Prosthesis

- An artificial replacement body part that may be missing or defective as a result of surgical intervention, trauma, disease or developmental anomaly, or
- A device to aid or augment the performance of natural bodily functions.

Reasonable

The charge for a service or a supply which is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished – as determined by the Claims Administrator. The Claims Administrator takes into account the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility and the prevailing charge in other areas. The DRG amount will be considered the reasonable charge if a hospital or other facility is required by law to charge the DRG amount.

Spinal Manipulative Therapy

Manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position.

2) Mental Health And Substance Abuse (Applicable to the Network and Comprehensive Non-Network Medical Plans)

Value Options Provider

- A licensed or certified psychiatrist, psychologist, psychiatric social worker, or other licensed mental health practitioner who has entered into an agreement with Value Options as an independent contractor to provide covered services to participants, or
- A state licensed facility, including a general acute care hospital or state licensed/authorized institution, program or other health facility whose services are covered under this Plan, which has entered into an agreement as an independent contractor with Value Options.

Certification or Certified

The decision by Value Options to certify treatment or proposed treatment as covered in accordance with this program and this Plan.

Covered Services

The Medically Necessary mental health or substance abuse care covered under this Program, except to the extent that such care is otherwise limited or excluded under this program or the Plan.

Emergency or Emergency Condition

A mental health or substance abuse condition determined by Value Options to require immediate medical diagnosis, attention or treatment in order to avoid a situation which could reasonably be exptected to:

- Cause the participant or another person harm, or
- Jeopardize the participant's life or cause the participant to jeopardize the life of another person.

Level of Care — The intensity and/or magnitude of a mental health or substance abuse care treatment setting, treatment plan or treatment modality including, but not limited to:

- Acute care facilities
- Less intensive inpatient or outpatient alternatives to acute care facilities, such as residential treatment centers, group home or structured outpatient programs
- Outpatient visits, or
- Medication management.

Medically Necessary — A service or supply which Value Options has established for benefits determination purposes to be:

- Provided for and consistent with the symptoms or proper diagnosis and treatment for the specific participant's illness, disease or condition, and
- Not primarily for the convenience of the participant, the participant's family, or the provider providing the service, and
- The appropriate level of care that can safely be provided for the specific participant's diagnosed condition in accordance with both generally accepted psychiatric and mental health practices and the professional and

Mental Health Care — Medically Necessary care provided by an eligible provider for the treatment of a mental health or behavioral illness or condition that Value Options has determined:

- Is a clinically significant behavioral or psychological syndrome or pattern, or
- Is associated with a painful symptom, or
- Substantially or materially impairs a person's ability to function in one or more major life activities, and
- Is recognized by the American Psychiatric Association as a mental health or behavioral illness or condition.

Network Benefit — The level of benefits that the Plan will pay when Covered Services are provided by a Value Options provider.

Non-Value Options Provider — A practitioner or facility whose services are covered by this Plan but which has not entered into an agreement, directly or indirectly, with Value Options to provide Covered Services to participants.

Out-of-Network Benefit — The level of benefits that the Plan will pay when Covered Services are provided by a non-Value Options provider.

Reasonable Charge

- The amount of the charge incurred for inpatient or outpatient Covered Services as a result of services provided by a Value Options provider which Value Options determines do not exceed the amount provided for in Value Options's applicable practitioner fee schedule or Value Options's negotiated facility rate, or

- For all other charges incurred for Covered Services for outpatient services, an amount which is the lesser of an amount provided above for each comparable type of provider or the normal charge that the specific provider would charge any other patient for the same service.
- For all other charges incurred for Covered Services for inpatient services at a facility, an amount which is the lesser of an amount determined by Value Options to be the Reasonable charge which is most often charged by other similar types of facilities to any other patient for the same Covered Services or the normal charge that the specific facility normally charges any other patient for the same Covered Service.

Expenses for services obtained from non-Value Options providers which exceed the Reasonable charge will be the responsibility of the participant.

Substance Abuse Care

Medically Necessary care provided by an eligible provider for the treatment of a substance abuse or chemical dependency illness or condition that Value Options has determined:

- Is a clinically significant behavioral or psychological syndrome or pattern, or
- Is associated with a painful symptom, or
- Substantially or materially impairs a person's ability to function in one or more major life activities, and
- Is recognized by the American Psychiatric Association as a substance abuse or chemical dependency illness or condition.

I. **Alliance Select Network Medical Plan Covering Employees in East Moline and Burlington**

	In-Network	Out-Of-Network
Annual Deductible	None	$100 per person $300 per family
Annual Out of Pocket Maximum	Not applicable	$1,000 per person $2,000 per family
Hospital Expenses	100% of network charges Precertification required	80% of R&C after deductible Precertification required
Hospice In-Patient Care	100% of network charges Precertification required	80% of R&C after deductible Precertification required
Surgical Services	100% of network charges	80% of R&C after deductible
Diagnostic X-ray & Lab Services	100% of network charges	80% of R&C after deductible
Ambulance	100% of network charges	80% of R&C after deductible

	In-Network	Out-Of-Network
Pap Smear	100% of network charge	80% of R&C after deductible
Organ Transplant	100% of network charges heart, heart/lung, lung, kidney/pancreas, bone marrow, liver, cornea, peripheral stem cell, skin grafts Precertification Required	80% of R&C after deductible heart, heart/lung, lung, kidney/pancreas, bone marrow, liver, cornea, peripheral stem cell, skin grafts Precertification Required
Mammograms	100% of network charges	80% of R&C after deductible
Durable Medical	100% for purchase or rental up to purchase price	80% of R&C after deductible for purchase or rental up to purchase price
Physician Services (Office visits)	100% of network charges	80% of R&C after deductible
Skilled Nursing	100% of network charges up to 730 days per confinement; renewal after 30 days	80% of R&C after deductible up to 730 days per confinement renewal after 30 days
Mental Health and Substance Abuse Treatment		
Inpatient	100% up to 45 days of confinement; renewal after 60 days Precertification required	80% of R&C after deductible up to 45 days of confinement; renewal after 60 days Precertification required
Mental Health and Substance Abuse Treatment		
Outpatient	100% up to 35 visits per year	80% of R&C after deductible up to 35 visits per year
Routine Physicals	100% of network charges	80% of R&C after deductible
Immunization	100% of network charges	80% of R&C after deductible
Prescription Drugs **Retail** (30-day supply) **Mail Order** (90-day supply)	 $2.00 co-pay $5.00 co-pay	 N/A N/A
Maximum Lifetime Benefit	$5,000,000 combined in and out-of-network limit	$5,000,000 combined in and out-of-network limit

Note: Coverage for employees of East Moline and Burlington is administered under the Alliance Select PPO, including mental health and substance abuse treatment, prescriptions and hearing benefits. Details of the coverage applicable to East Moline and Burlington are provided in a separate Summary Plan Description.

J. **Coordination of Benefits With Other Group Plans**

When services or benefits for covered medical expenses under this Plan are also provided under any other Group Insurance or Group Prepayment Plan, the Benefits payable under this Plan are subject to reduction to the extent necessary to make such benefits, together with the benefits payable or the value of the services available under all other such plans, during any one calendar year, equal to the total amount of "Allowable Expenses" as defined below. In no event, however, will benefits payable under this Plan be more than would have been payable in absence of the coordination of benefits provision.

An "Allowable Expense" is any reasonable, necessary and customary item of expense at least a portion of which is covered under any one of the Group Insurance or Group Prepayment Plans covering the person for whom claim is made.

III. DENTAL EXPENSE BENEFIT PLAN

Covered dental expenses are the reasonable and customary charges for eligible services. These services must be performed or prescribed by a dentist and necessary in terms of generally accepted dental standards. The reasonable and customary charge is the lowest of:

1) The usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or

2) The usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or

3) The actual charge for the services or supplies.

The Administrator has developed a profile on individual dentists for the purpose of establishing guidelines for reasonable and customary charges for each dentist. Factors considered for each dentist may vary within the same locale, but generally reflect the relative cost to each dentist in conducting his practice. As a result, the Administrator's determination of reasonable and customary charges may vary slightly from dentist to dentist.

The following dental services may be covered dental expenses, subject to the following Plan limitations:

- The maximum benefit payable for all covered Type B and Type C dental expenses incurred in any calendar year is $1,500. This maximum applies individually to each eligible employee or dependent.

- The maximum benefit payable for orthodontic treatment, Type D, will be $1,550 for all expenses incurred during the lifetime of the eligible employee or dependent. The maximum benefit will be provided to eligible participants even if the participant is currently undergoing orthodontic treatment.

A. Type A Expenses

The following will be paid at 100% of the reasonable and customary charges and such procedures shall not be subject to an annual maximum.

1) The excision of partially or completely unerupted or impacted teeth;

2) The excision of the tooth root (apicoectomy) without the extraction of the entire tooth;

3) Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction of or repair of teeth (but not including treatment of periodontal and other diseases of the gums and tissues of the mouth).

4) Multiple extractions while patient is an in-patient/out-patient in a hospital or free standing surgi-center when a concurrent hazardous medical condition exists;

5) Gingivectomy procedures, if performed in connection with the treatment of diseased gums;

6) Periodontal surgery

7) Topical application of fluoride;

8) Space maintainers that replace prematurely lost teeth for dependent children under 19 years of age;

9) Emergency palliative treatment; and

10) X-rays and anesthesia done as part of an orthodontic procedure.

B. Type B Expenses

The following procedures shall be paid at 100% of the reasonable and customary charges and are included in the $1,500 annual maximum.

1) Two oral examinations including cleaning and scaling of teeth within each calendar year (January 1 through December 31).

2) Dental X-rays, but not more than one full mouth X-ray in any period of thirty-six consecutive months; and supplementary bitewing X-rays, but not more than twice in any period of twelve consecutive months except that one additional full mouth x-ray will be covered in a thirty-six month period and one additional bitewing x-ray will be covered in a twelve-month period is necessary for treatment of a diagnosed condition; The plan will cover such other dental X-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

3) Extractions.

4) Oral Surgery.

5) Fillings.

6) General anesthetics administered in connection with oral surgery or other covered dental services.

7) Treatment of periodontal and other diseases of the gums and tissue of the mouth but not surgical procedures; acetate treatment for periodontal disease will be covered.

8) Endodontic treatment, including root canal therapy.

9) Injection of antibiotic drugs by the attending dentist, including Decatron.

10) Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures.

11) Inlays, gold fillings, crowns (including precision attachments for dentures).

12) Dental sealants for teeth numbers 2,3,14,15,18,19,30 and 31 for children under age 19.

13) Cosmetic bonding of eight front teeth (numbers 5-12 and 21-28) for children ages 8 through age 19 if required because of severe tetracycline staining, severe fluorsis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three consecutive calendar years.

C. Type C Expenses

The following procedures shall be covered at 50% of the reasonable and customary charge and are included in the $1,500 annual maximum.

1) Initial installation of fixed bridgework (including inlays and crowns to form abutments).

2) Initial installation (including adjustments) of partial or full removable dentures. Adjustments are limited to a six-month period following installation.

3) Replacement of, or the addition of teeth to, existing full or partial removable dentures or fixed bridgework if:

(a) Required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,

(b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable. (This five-year rule only applies to dentures or bridgework for which benefits were payable under this Plan or any other group plan); or,

(c) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve months.

D. Type D Expenses

The following procedures shall be covered at 50% of the reasonable and customary charge and are limited to a lifetime maximum of $1,550.

Orthodontic treatment consisting of surgical therapy, appliance therapy and functional/myofunctional therapy.

Reimbursement for orthodontic treatment will be made on a claims-incurred basis. Where it is possible to determine the portion of charges for such treatment attributable to the period prior to commencement of coverage and the portion attributable to the period subsequent to commencement, the Dental Plan will pay the portion of the charges determined to be incurred subsequent to the commencement of coverage. Where it is not possible to apportion the charge on a basis of proportionate services, the Administrator will attempt to make a reasonable apportionment.

Thus, claims for orthodontic services received prior to the effective date of coverage will not be covered, however, services received while covered by the Plan will be covered. Further, in the event of a plan limit change, claims will be processed based on the Plan limit in effect on the date service was received.

E. Dental Expenses Not Covered

The following dental services are not considered eligible dental expenses:

1) Service or supplies received prior to eligibility for dental benefits.

2) Services not performed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:

(a) Cleaning and scaling of teeth; or

(b) Fluoride treatments.

3) Cosmetic surgery, treatment or supplies (except as noted in B.13.) including charges for personalization or characterization of dentures (such as the capping of healthy natural teeth).

4) Replacement of lost, missing or stolen crown, bridge or denture.

5) Repair or replacement of an orthodontic appliance.

6) Services or supplies which are covered by Worker's Compensation or occupational disease laws.

7) Dentures, bridges, crowns, inlays, onlays and their fittings, delivered or installed more than sixty days after the employee's coverage ended.

8) Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.

9) Services or supplies which are unnecessary, according to accepted standards of dental practice, or which do not meet these standards, or which are experimental in nature.

10) Any duplicate appliance or prosthetic device.

11) Use of materials such as sealants (other than that specified in B.12.) used to prevent decay other than fluorides.

12) Instruction for oral care such as hygiene or diet.

13) Periodontal splinting.

14) Myofunctional therapy or correction of harmful habits, other than for orthodontia.

15) Non-surgical treatment for Temporomandibular Joint Syndrome.

16) Implantology.

17) Services or supplies received by a covered person for which no charge would have been made in the absence of Dental Expense Benefits for that covered person.

18) Services or supplies for which a covered person is not required to pay

19) Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the covered person are in effect.

20) Services or supplies to the extent that benefits are otherwise provided under this Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.

21) Charges for appointments not kept.

22) Charges by the dentist for completing dental forms.

F. Alternate Benefits

The Dental Expense Benefit Plan provides for payment of expenses based on the materials and method of treatment which is the least costly method, yet meets generally acceptable dental standards.

1) Fillings, Inlays, Onlays & Crowns

If a tooth can be repaired by a less costly method than inlay, onlay or crown, Dental Expense Benefits will be based on the adequate method of repair which costs the least.

2) Crowns, Pontics & Abutments

Veneer materials may be used for front teeth or bicuspids. However, Dental Expense Benefits will be based on the adequate veneer materials which cost the least.

3) Bridge Work & Dentures

Dental Expenses Benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the Dental Expense Benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

G. Pre-Determination of Benefits

If a dental bill is expected to be $125 or more, before the Dentist starts the treatment, an employee can find out what Dental Expenses Benefits will be paid under this Plan. To do this, the employee should send a claim form in which the dentist advises:

1) The work to be done; and,

2) What the cost will be.

The Administrator will then advise the employee what Dental Expense Benefits the Plan will pay. If the employee does not use this method to find out what Dental Expense Benefits the Plan will pay, the Administrator's decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Expense Benefits the Plan will pay.

The pre-determination method should not be used for:

1) Emergency treatment; or

2) Routine oral exams; or

3) X-rays, cleaning and scaling, and fluoride treatments; or

4) Dental services which cost less than $125.

H. Dental Expense Coverage After Benefits End

No benefits will be payable for Covered Dental Expenses incurred by a Covered Person after the Dental Expense Benefits for that person end. This will apply even if a pre-determination of benefits for dental services has been approved. However, benefits for Covered Dental Expenses incurred for a Covered Person for the following services will be paid after Dental Expense Benefits end:

1) For a prosthetic device if:

   (a) The dentist prepared the abutment teeth and made impressions while the Dental Expense Benefits for the covered person were in effect; and,

   (b) The device is installed within sixty days after the date the Dental Expense Benefits end; or

2) For a crown if:

   (a) The Dentist prepared the tooth for the crown while the Dental Expense Benefits for the Covered Person were in effect; and,

   (b) The crown is installed within sixty days after the date the Dental Expense Benefits end; or

3) For root canal therapy if:

   (a) The dentist opened the tooth while the Dental Expense Benefits for the Covered Person were in effect; and

   (b) The treatment is finished within sixty days after the date the Dental Expense Benefits end.

IV. VISION SERVICE PLAN

The vision coverage program is administered through Vision Service Plan (VSP). This company has developed a nationwide network of vision care professionals,. You can choose to use this network by going to a network doctor, or you can be reimbursed in part for getting your routine eye care from a doctor who is not a member of the VSP network.

If you use the network, covered services are prepaid with no deductible. If you use the services of a doctor who is not a participant in the network, the program reimburses you for covered expenses according to a schedule of benefits.

A. What the Program Covers

Through VSP's network, member doctors agree to perform services at agreed-upon fees. If you use any other doctor, the program pays a portion of the costs based on a schedule of fees for certain covered services.

1) Using a VSP doctor

If treatment is by a VSP network doctor, the program pays:

(a) 100% for an annual routine eye examination.

(b) 100% each year for lenses. This includes single vision, bifocal and trifocal lenses as well as tinted and photochromic lenses. If a doctor prescribes other more complex and expensive lenses that are medically necessary, they are covered in full.

(c) 100% each year for most frames. The program offers a wide choice of frames. You pay the difference between the wholesale price for the standard frames and the wholesale price of the optional frames.

(d) 100% each year for contact lenses *"medically necessary"* for any of these conditions:
- following cataract surgery,
- to correct extreme vision problems that cannot be corrected by eyeglasses,
- certain conditions of anisometropia, and
- keratoconus.

(e) $150 total for the eye exam and contact lenses that are not medically necessary (i.e. medically necessary means your vision cannot be corrected with eyeglasses).

If the employee or dependent gets contacts, any eyeglasses purchased for that person will not be covered that calendar year.

2) Using a nonparticipating doctor

Instead of going to a VSP doctor, members can be treated by the licensed optometrist, ophthalmologist or eye specialist of their choice. When they go to the doctor or purchase eyeglasses or contact lenses, they will pay the full cost, then apply for partial reimbursement from the program. Each calendar year, the program pays for each covered family member:

(a) Up to $35 for an annual routine eye examination.

(b) Up to:
- $35.00 a pair for single vision lenses.
- $52.50 a pair for bifocal lenses.

- $70.00 a pair for trifocal lenses.
- $87.40 a pair for lenticular lenses.
- $5.00 for tinting.

(c) Up to $35 a pair for frames.

(d) Up to $200 a pair for medically necessary contact lenses. VSP must approve the medically necessary lenses before members can receive reimbursement for them. Contacts are considered medically necessary:
- following cataract surgery,
- to correct extreme vision problems that cannot be corrected by eyeglasses,
- certain conditions of anisometropia , and
- keratoconus.

If vision can be corrected with eyeglasses but the member decides to purchase contact lenses, the program will pay $150 toward the cost of the eye exam and elective contact lenses. This benefit is the same regardless of whether the member goes to a VSP participating doctor or not.

B. Optional Services

The vision program is designed to provide necessary eye care and corrective eyeglasses.

If a member wants to purchase certain optional services, they can buy these extras for additional cost. The VSP doctor can tell them whether something is covered by the program or is considered an option.

Examples of options for which members will pay extra money include:

- Blended lenses,
- Oversize lenses,
- Progressive multifocal lenses, e.g., progressive bifocals,
- Coated or laminated lenses,
- Frames costing more than the program allowance,
- Certain costs for low vision care,
- Cosmetic lenses (lenses for eyeglasses that serve no corrective vision purpose),
- Ultraviolet-protected lenses, and
- Optional cosmetic processes.

C. Expenses Not Covered

The vision program does not pay any benefits for:

- Orthoptics or vision training and any associated supplemental testing,
- Plano lenses (noncorrecting),
- Two pairs of glasses instead of bifocals,
- Medical or surgical treatment for the eyes. (This may be covered by the medical coverage, if enrolled in that program,)
- Any eye examination or corrective eyewear required by an employer as a condition of employment,
- Lost, stolen, or broken eyeglasses or contact lenses,
- More than one pair of eyeglasses or contact lenses during the calendar year.

One other important note: Members must show their VSP benefit voucher at the network doctor's office to receive VSP benefits. Otherwise, they may be billed as a private patient. In this case, the member

may apply to VSP for reimbursement as non-network expense and the member will pay any charges above what the program pays.

V. HEARING AID PLAN

A Hearing Aid Expense Benefits Plan for eligible active employees, retired employees, surviving spouses receiving pensions and the dependents of each of the above, will be provided.

This plan is available to those employees and retirees who do not have hearing and hearing aid coverage under their medical plan.

The Hearing Aid Expense Benefits Plan will provide benefits according to the following schedule, and under the terms stated:

1) Payment for the actual charges to the extent that such charges are usual, reasonable and customary, and do not exceed the maximum amount for such services specified below:

Covered Hearing Aid Services	Maximum Amount Payable
Audiometric Examination	$ 35.00
Hearing Aid Evaluation Test	$ 35.00
Hearing Aids	$350.00 for a regular hearing aid or $700.00 for a binaural hearing aid

2) The following describes the Hearing Aid Expense Service in detail:

(a) Audiometric examination, when performed by a Doctor or Audiologist, but only when performed following or in conjunction with a Doctor's most recent medical examination of the ear. The maximum amount payable for such exam is $35.00.

(b) Hearing aid evaluation tests performed by a Doctor or Audiologist, which may include the trial and testing of various makes and models of hearing aids to determine which make and model will best compensate for the loss of hearing acuity but only when indicated by the recent audiometric examination. The maximum payment for such tests is $35.00.

(c) Hearing aids of the following functional design: in-the-ear, behind-the-ear (including air conduction and bone conduction types) and on-the-body, but only if (1) the hearing aid is prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation examination; and (2) the hearing aid provided by the Dealer is the make and model prescribed by the Doctor or Audiologist and is certified as such by the Doctor or Audiologist. The maximum payment for a hearing aid is $350 for a regular hearing aid or $700 for a binaural hearing aid.

(d) If a covered Employee or Dependent has received an audiometric examination, a hearing aid evaluation test or a hearing aid for which benefits were payable under the Plan, benefits will be payable for any such subsequent audiometric examination, hearing aid evaluation test or hearing aid only if received more than 36 months after receipt of the most recent previous audiometric examination, hearing aid evaluation test or hearing aid, respectively, for which benefits were payable under the Plan.

(e) Replacement of a hearing aid will not require a physicians examination prior to the replacement.

3) The Company will attempt to establish provider contracts with suppliers of materials and services described in Paragraph (1) above. The establishment of such contracts shall provide audiometric examination, hearing aid evaluation tests, and pre-determined selection of hearing aids without cost to the employee, except for the cost of such services in excess of the amount in Paragraph (1).

4) The following services and supplies are not covered Hearing Aid Plan services or supplies:

(a) Charges for which benefits are otherwise provided under the Group Policy.

(b) Charges for audiometric examination by and Audiologist that are not ordered by a Doctor.

(c) Charges for medical treatment including medical examination of the ear.

(d) Charges for the replacement of hearing aids that are lost, missing or stolen if such replacement takes place within 36 months following the date of the receipt of such device.

(e) Charges for failure to keep a scheduled visit with the Doctor.

(f) Charges for services or supplies in connection with repairs or servicing of the hearing aids or for replacement parts.

(g) Charges for audiometric examinations and hearing aid evaluation tests performed and hearing aids ordered:

1. Before the Covered Person became eligible for coverage; or

2. After the termination of coverage of the Covered Person.

(h) Charges for hearing aids ordered while covered but delivered more than sixty days after termination of coverage.

(i) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by a Doctor.

(j) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids that do not meet profession accepted standards of practice, including charges for any such services or supplies that are experimental in nature; and tinnitus maskers or instruments or any other device which does not amplify sound and assist the physiologic process of hearing.

(k) Charges for the completion of any insurance forms.

(l) Charges for eyeglass-type hearing aids, to the extent the charges for such hearing aid exceeds the covered hearing aid expense for one hearing aid.

VI. GENERAL

A. Eligibility

1) An employee shall be eligible for coverage on his own account on the day immediately following the completion of the length of continuous service noted below, provided that the employee is actively at work on that day (unless otherwise required by federal regulation).

Waiting Periods for Employees Hired or Rehired on or After May 18, 1998:

(a)	Life, AD&D, and Case Health Care Plans	3 months
(b)	Weekly A&S Benefits	3 months
(c)	Dental Coverage	18 months
(d)	Vision Service Plan	18 months
(e)	Hearing Care Coverage	18 months
(f)	Long Term Disability	24 months

2) Dependent's coverage shall be effective:

(a) On the effective date of the Employee's coverage provided the dependent is not confined in a hospital or other institution for care or treatment; or is not confined at home under the care of a physician or surgeon because of a disabling physical or mental sickness or injury. If so confined or disabled, coverage for that dependent shall not be effective until he or she has been discharged from the hospital or other institution, or is no longer confined at home under the care of a physician.

(b) Upon enrollment for Dependent Coverage by the employee, provided enrollment is made within thirty-one days of the date the employee acquires the dependent; in which case coverage will become effective on the date the person becomes the dependent of the employee.

B. Cessation of Coverage

1) Coverage shall automatically cease on the date employment terminates. For purposes of coverage, termination of employment means cessation of active work as an employee, except that in circumstances specified below and as provided by Paragraphs C, D and E which follow:

(a) Life Insurance benefits shall continue to be payable for thirty-one days thereafter.

(b) If on the date of cancellation the employee or dependent is totally disabled and under the care of a physician, Major Medical Expense coverage will continue to be paid in accordance with the provisions of the Policy during the continuance of the total disability, but not beyond the end of the calendar year following the calendar year in which such coverage is canceled.

2) The following Conversion Privileges shall be available upon cancellation of the group coverage:

(a) Life insurance up to the amount provided under the Group Plan may be continued under an individual policy, without evidence of insurability, provided application is made to the Insurance Company within thirty-one days of the cancellation date. The amount of such individual policy may, at the option of the Employee, be increased by an amount equal to the total amount of Survivor Income Benefits Insurance payments (Transition and Bridge) that would have been made if the employee had died on the date of termination of employment.

(b) Medical Expense Insurance may be obtained under an individual policy without evidence of insurability, for the employee and dependents, if the dependents had been insured under the Group Plan as of the cancellation date, provided application is made to the Insurance Company within thirty-one days following the cancellation of coverage under the Group Plan.

C. Provisions Applicable to Employees on Lay-Off

1) The following Group Coverage which was in effect as an active employee shall be continued in effect as applicable as stated below for employees who cease active work due to a lay-off:

(a) Coverage for Employees Only

1. Group Life Insurance
2. Accidental Death & Dismemberment
3. Survivor Income Benefits (Transition & Bridge)

(b) Coverage for Employees & Dependents

1. Medical Plan
2. Prescription Drug Plan
3. Dental Plan
4. Vision Plan
5. Hearing Plan

2) An employee placed on lay-off will have certain group coverages continued according to the following schedule:

(a) Coverage Based on SUB Credits

All coverages listed above (1) shall be continued for one full calendar month of lay-off, not to exceed twelve (12) months, for each full four weeks of regular benefits to

which the employee's credits would entitle him on the basis of his seniority and credit unit cancellation base as of the last day of work prior to lay-off.

(b) Coverage Based on Seniority for employees hired prior to May 18, 1998.

Year(s) of Seniority On Date Lay-Off Begins	Months of Extended Coverage
Less than 4	6
4 but less than 5	8
5 but less than 6	10
6 and over	12

Employees hired on or after May 18, 1998

Years of Seniority	Weekly Benefit	Maximum Duration
1 up to 5	$100	26 weeks
5 up to 10	$125	39 weeks
10+		
UC eligible	$200	26 weeks
UC ineligible	$250	52 weeks

The continuation will be based upon the greater of the above calculations. The employee shall have the conversion privileges available upon expiration of the period of continued group coverages listed above.

An employee with ten or more years of seniority at the time of lay-off due to a full or partial plant closing will receive an additional twelve months of Group Life Insurance & Medical coverage (including prescription drugs), excluding Dental, Vision and Hearing Benefits.

3) Conversion Privileges

The Conversion Privileges described in Paragraph B 2a and b above, shall be available to employees upon expiration of the period of continued Group Coverage listed above.

D. Provisions Applicable to Employees on Disability Leave of Absence

A disabled employee will be eligible to continue coverage in effect as an active employee for Life, Medical, Dental, Prescription Drug, Vision and Hearing coverage at the Company's expense for the period during which he receives Weekly Accident and Sickness benefits and Long-Term Disability benefits.

1) Conversion Privilege

The Conversion Privileges described in Paragraph B 2a and b above shall be available to employees upon expiration of the period of continued Group Coverage listed above.

E. Maternity Leave of Absence

Employees placed on Leave of Absence for maternity will be permitted to continue Life, Medical, Dental, Prescription Drug, Vision and Hearing coverages at normal active employee rates, if required for up to twelve (12) months following the date the Leave of Absence commenced. The coverage shall include eligible dependents.

F. Contested Worker's Compensation Claim

In the event of a contested claim for Worker's Compensation Benefits, the following procedure will be followed:

1) With regard to medical services, the Company physicians, at their discretion, may either treat the employee, refer him to an outside physician, or permit him to go to a physician of his choice (subject to applicable State law).

2) The employee shall receive an amount of money equal to his current Weekly Indemnity rate, but this benefit will not be considered either Weekly Indemnity or Worker's Compensation until such time as the dispute is finally resolved.

3) The employee will be required to sign a reimbursement form which will provide that any Worker's Compensation judgment in favor of the employee which duplicates a payment previously made by the Company, will be returned to the Company by the employee, or deducted from any final settlement the Company may be required to make.

The above action taken while the dispute is pending will in no way impair the rights of the employee or the Company nor be used to prejudice the position of either.

G. Leave of Absence

1) Union Business

Medical, Dental, Prescription Drug, Vision and Hearing coverage will be continued at Company expense consistent with that applicable to active employees, during an approved leave of absence requested by the Local Union to permit an employee to work on a full-time basis for the Local Union for a period not longer than the balance of the month in which the leave commenced plus the following full calendar month. Thereafter, the employee shall be entitled to continue such coverage by paying the full cost thereof.

2) Personal

The group coverage (life insurance, accidental death & dismemberment, survivor income benefit insurance, medical, dental, prescription drug, vision and hearing) shall be continued in force for the month following the month in which the Leave commences.

H. Special Age 65 Benefit (Medicare Payment)

1) The Special Age 65 Benefit (Medicare payment) shall be payable to active employees age 65 or older and on behalf of the employee's spouse if covered by Medicare Part B. The Medicare payment shall be payable to disabled employees who are eligible for Medicare Part B during the period they are receiving Long Term Disability Benefits and monthly installment Life Insurance Benefits.

The Medicare Payment shall be increased on the date(s) indicated:

April 1998	$59.40 or actual amount if less
January 1, 2001	$62.00 or actual amount if less
January 1, 2002	$65.50 or actual amount if less

2) In addition, the Medicare Payment is payable on behalf of:

a) Employees who retired on a company-provided pension after 7/1/94;

b) The eligible spouse of retired employees who retired after 7/1/94; or

c) Surviving spouses of employees who retired after 7/1/94, receiving a spouse's pension or who will receive a spouse's pension upon exhausting Transition and Bridge benefit payments.

3) If the company provided coverage is primary for active employees and their eligible dependents or disabled employees and their eligible dependents, the company will not reimburse the employee (active or disabled) or eligible dependents the Medicare Part B premium.

The retired employee, spouse, or surviving spouse must be enrolled for Medicare Part B. The benefit is not payable, however, if a Medicare repayment is being paid on behalf of the retired employee or spouse from another source.

This benefit is not applicable to former employees or spouses of former employees receiving a pension due to eligibility under the Pension Plan provisions for deferred, vested benefits.

I. Provisions Applicable to Employees Retired on Company Pension and Surviving Spouses Receiving Company Pension

1) Employees who retire under the Case Corporation Pension Plan for Hourly Paid Employees after 7/1/94, or their surviving spouses eligible to receive a spouse's pension under the provisions of that Plan, shall be eligible for the Group benefits as described in the following paragraphs. All other coverages cease coincident with the date of employment termination due to retirement. (The provisions of this section shall not apply to individuals eligible for or receiving retirement benefits under the deferred vested provisions of the Pension Plan.)

(a) The following benefits will apply to employees who retire on/or after the dates noted and who have ten (10) or more years of service at the retirement date.

Group Life Insurance - Disability Retired Employees Only

1. Employees retiring on Company-provided pensions due to permanent and total disability, in which the disability commenced after July 1, 1974, shall have the amount of their Group Life Insurance continued in an unreduced amount until attainment of Age 65. At Age 65, the Life Insurance shall be reduced by 25%, then reduced again by 25% of the original active amount upon attainment of age 66. The resulting benefit will 50% of the original active amount.

Group Life Insurance - Retired Employees Only

1. For employees who retire after July 1, 1994 and prior to April 1, 1998, the benefit will be $10,500 until age 65 and $7,000 thereafter.

2. For employees who were hired prior to May 18, 1998, and who retired on or after April 1, 1998, the benefit will be the same as their life insurance level as an active employee until age 65. At age 65, the benefit level will be reduced by 25%; at age 66, the benefit will be reduced again by 25% of the original amount.

3. Employees hired after May 18, 1998, have $7,500 of life insurance after they retire.

Group Health Care

1. The following benefits will apply to employees who retire on/or after the dates noted who have ten (10) years of service at the retirement date, or surviving spouse eligible to receive a spouse's pension under the provisions of the Pension Plan.

Medical*	Vision
Prescription Drug	Hearing
Dental	

*Eligibility for specific coverage based on each plan's eligibility requirements.

2. Employees hired after May 18, 1998, are not eligible for health care coverage.

(b) The following benefits will apply to employees who retired with five but less than ten years of credited service.

Group Life - Retired Employees Only

1. For employees who retire after July 1, 1994, and prior to April 1, 1998, the life insurance benefit will be $2,500.

2. For employees hired prior to May 19, 1998, who retire on or after April 1, 1998, will have life insurance equal to the level in effect as an active employee, until age 65. At age 65, the life insurance will be reduced by 25%; then reduced again by 25% of the original active amount upon attainment of age 66. The resulting benefit will be 50% of the original active amount.

3. Employees hired on or after May 18, 1998, will have $7,500 of life insurance upon retirement.

Group Health Care

The following benefits will apply to all currently retired employees, or surviving spouse eligible to receive a spouse's pension under the provisions of the Pension Plan.

Medical*
Prescription Drug Plan

The retiree or surviving spouse is not eligible for Dental, Vision, or Hearing coverages.

Employees hired after May 18, 1998 are not eligible for health care coverage.

(c) The following benefits will apply to employees who retire with less than five years of credited service.

Group Life - Retired Employees Only

No coverage is provided.

Group Health Care

The following benefits will apply to all currently retired employees, or surviving spouse eligible to receive a spouse's pension under the provisions of the Pension Plan.

Medical*
Prescription Drug

The retiree or surviving spouse is not eligible for Dental, Vision, or Hearing coverages.

Employees hired after May 18, 1998 are not eligible for health coverage.

2) Enrollment

Eligible Retired Employees and Surviving Spouses are required to complete enrollment in accordance with Group Policy provisions for the continued coverages as described above, and provide evidence of enrollment in Part B, Medicare, as required. In the event of the inability of a Retired Employee or Surviving Spouse receiving a Spouse's Pension to enroll in Medicare Part B because of an enrollment restriction, the requirement of enrollment will be waived until their first opportunity to become enrolled.

3) Contribution for Coverage

(a) Group Life Insurance as stated above shall be fully paid by the Company.

(b) 1. No contributions are required for the Health Care Plans, Dental Plan, Vision Plan and Hearing Plan.

2. Dependents Age 65 and Over – Not qualified for Medicare

With respect to dependents who are Age 65 and over and who do not qualify for Medicare, for reasons other than non-payment of premium, the Company will either cover the dependent under its HMSD program without a reduction for benefits otherwise provided by Medicare, or provide Medicare reimbursement. The company will notify the Union of its decision in each case.

J. **Deferred, Vested Retirees & Surviving Spouses of Deferred, Vested Retirees**

The provisions of this agreement are not applicable to individuals eligible for or receiving a pension benefit under the provision for Deferred, Vested, Retirement of the Pension Plan, or Surviving Spouses receiving a Spouse's Pension resulting from a Deferred, Vested Retirement.

K. **Subrogation**

In the event of any payment of medical/hospital, dental, vision or hearing benefits under this Plan for which an employee, retiree, surviving spouse or a dependent may have a claim or cause of action against any person or organization (except a claim or cause of action against an employer and except against insurers of policies of insurance issued to, and in the name of the employee, retiree, surviving spouse, or dependent) Case or the Administrator shall be subrogated to all right of recovery of the employee, retiree, surviving spouse or dependent with respect to any expenses included in any judgment of settlement only to the extent that said judgment or settlement is expressly identified as a payment for medical/hospital, dental, vision or hearing services paid for under this Plan. If the employee, retiree, surviving spouse or dependent incurs attorney's fees in connection with the successful prosecution or settlement of any claim or cause of action which includes such benefits, the employer or Administrator, as the case may be, shall reduce its right of subrogation by a pro rata share of such attorney's fees based on the ratio of the amount of any such medical/hospital, dental, vision or hearing benefits paid under this Plan to the total amount recovered by settlement of judgment. The employee, retiree, surviving

spouse or dependent shall, at the request of the Company or Administrator, execute and deliver such instruments and papers as may be required and to take such other reasonable steps necessary to secure the subrogation rights.

In cases where subrogation is involved, Case will proportionally reduce its subrogation interest under the claims of its employees and their dependents when the actual amount recovered reflects less than the proper value of the case* and a reasonable basis exists for accepting such lesser amount in settlement.

To illustrate, assume a liability case has a value of $100,000, but a defendant has only $50,000 coverage and no other available assets, and that a settlement between the plaintiff and the defendant is reached for $50,000. Assume also that the monies expended by Case for medical and hospital bills for the plaintiff employee or dependent totaled $10,000. If advised of these facts, and having ascertained their accuracy, Case would proportionalize its subrogation interest and treat its original $10,000 amount expended as if it were only $5,000. Thus, to the same extent the employee or dependent is deprived of proper compensation for the injury (50% in this example), Case also proportionalizes its subrogation interest (50%).

Assuming such a settlement, the recovery by Case would not be of $5,000, but $3,335.

*A proper value of a case is estimated by multiplying the financial loss (medical bills, lost time and property) by five.

L. Compliance with Federal Law

To comply with the Federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA), the following applies:

The law provides employees, their spouses and dependent children, the option of continuing group coverage, for specified periods, after the termination of their coverage.

The period of continuation depends on the reasons coverage terminates, as illustrated below:

	Coverage Continuation
Termination of Employment	18 months

The continuation will be provided to employee and, if applicable, to employee's eligible dependents.
(Up to 29 months of extended coverage if determined to be disabled under Social Security, or become disabled within the first 60 days of COBRA coverage. This also applies to all qualified family members.)

Dependent Born to (or adopted by) a COBRA Beneficiary
Such dependent is also considered a qualified beneficiary and eligible for COBRA for the same period of time remaining for the qualified member.

Death of Employee	36 months

The continuation will be provided to the surviving spouse and, if applicable, dependents of deceased employee.

Divorce of Employee/Spouse	36 months
The continuation will be provided to the ex-spouse and, if applicable, eligible dependents.	
Dependent Child No Longer Eligible	36 months
The continuation will be provided to the eligible dependent child when no longer eligible for coverage.	

The Group Coverage may be continued by paying the applicable premium rate. In situations where the Company already provides continued coverage for all or part of the period specified at no cost to employee/spouse/dependent, the period of continuation will include the months the Company provides. As an example, in the event of a lay-off, if Group Coverage would be continued for twelve months at no cost to employee, the employee would be able to continue Group Coverage for an additional six months by paying applicable premiums.

Benefits may be elected separately as follows:

- Medical/Prescription/Hearing
- Dental
- Vision

Or, a combination of some or all three.

M. Coordination of Benefits

1) Definitions

(a) "Plan" means a plan which provides benefits or services for or by reason of medical care and which is:

1. a group insurance plan; or
2. a group blanket plan; or
3. a group practice plan; or
4. a group service plan; or
5. a group prepayment plan; or
6. any other plan which covers people as a group; or
7. a government program or coverage required or provided by any law, including any motor vehicle no-fault coverage which is required by law.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan. Each part of such a Plan which reserves the right to take the benefits or

services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

(b) "This Plan" means only those parts of This Plan which provide benefits or services for medical care. The provisions of This Plan which limit benefits based on benefits or services provided under:

1. Government Plans; or

2. Plans which the Employer (or an affiliate) contributes to or sponsors; will not be affected by this Coordination of Benefits provision.

For the purpose of applying this provision, if both spouses are covered as Employees under This Plan, each spouse will be considered as covered under separate Plans.

(c) "Allowable Expense" means any reasonable and customary charge which meets all of the following tests:

1. It is a charge for an item of necessary medical expense; and

2. It is an expense which an Employee or Dependent must pay; and

3. It is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

When a Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Plan will be deemed to be Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expense does not include expense for services received because of:

1. an occupational sickness; or

2. an occupational injury.

(d) "Claim Determination Period" means a period which starts on any January 1st and ends on the next December 31st. However, a Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

2) Effect on Benefits

(a) The benefits payable under This Plan will not be reduced on account of benefits payable under another Plan if:

1. The other Plan has a Coordination of Benefits or similar provision with the same order of benefit determination as Subsection C of this Section 2; and

2. Under that order of benefit determination, the benefits under This Plan are to be determined before the benefits under the other Plan.

(b) Unless Subsection A of this Section 2 applies, when the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are less than the sum of:

1. The benefits that would be payable under this Plan without applying this Coordination of Benefits provision; and

2. The benefits that would be payable under all other Plans without a Coordination of Benefits or similar provisions;

the benefits described in Item B1 of this Section 2 will be reduced. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of the Allowable Expenses. Benefits payable under other Plans include all benefits that would be payable if the proper claims had been given on time.

(c) When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:

1. Non-Dependent/Dependent - The Plan which covers that person other than as a dependent determines its benefits before the Plan which covers that person as a dependent.

2. Dependent Child/Parents Not Separated or Divorced -Except as stated in Rule 3 below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents", benefits for that child will be determined in this order:

a. The Plan of the parent whose date of birth (excluding year of birth) falls earlier in a year, determines its benefits before the Plan of the parent whose date of birth (excluding year of birth) falls later in that year. If both parents have the same date of birth (excluding year of birth), the Plan which covered the parent for the longer time determines its benefits before the Plan which covered the other parent for the shorter time.

If either Plan which covers the person has not adopted the above rule, both Plans will determine their benefits by determining the father's benefits before the Plan of the mother.

3. Dependent Child/Separated or Divorced Parents - If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for that child will be determined in this order:

   a. First, the plan of the parent with custody of the child;

   b. Then, the Plan of the spouse of the parent with custody of the child; and

   c. Finally, the Plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity which is obligated to pay or provide the benefits of the Plan of that parent was actual knowledge of those terms, the Plan which covers the child of that parent determines its benefits first. Then follow the above Rules 3.(a), (b) or (c) to determine which Plan pays next. This paragraph does not apply with respect to any Claim Determination period during which any benefits are actually paid or provided before that entity has that actual knowledge.

4. Active/Laid-Off or Retired Employee - The Plan which covers that person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if as a result, the Plans do not agree on the order of benefits, this Rule 4. will not apply.

5. Longer/Shorter Time Covered - If none of the above rules 1, 2, 3 or 4 determines the order of benefits, the Plan which has covered that person for the longer time determines its benefits before the Plan which covered that person for the shorter time.

   a. Any reduction in the benefits under this Plan will be applied proportionately to each benefit that would have been paid in the absence of this Coordination of Benefits provision.

3) Exchange of Information and Payments

(a) We may, without the consent of or notice to any person, give or receive any information about coverage, expenses and benefits which is needed to apply this provision.

(b) To obtain all benefits available, a claim should be filed under each Plan which covers the person for whom Allowable Expenses were incurred. Any person who claims benefits under this Plan must give to us the information we need to apply this provision.

(c) We have the right to recover any overpayment we make under this Plan from any party who benefited from the overpayment.

(d) If payments which should have been made under this Plan were made under any other Plans, we may pay the party which made the other payments any amounts which we deem proper under this provision. Amounts so paid will be deemed benefits under this Plan. We will be fully discharged from liability under this Plan to the extent of such payments.

N. Pre-Certification - Active & Retirees
(Past and future who are not eligible for Medicare)

1) This program is designed to involve the employee and the physician in controlling health care costs under the Medical Network and the Comprehensive Non-Network Plan. (A separate precertification process applies to Substance Abuse and Mental Health conditions. See number 6 at the end of this section for details.)

If an employee or one of his dependents is being scheduled for non-emergency hospitalization, the physician has to participate in the Pre-Certification Review.

-- Have the physician call the toll-free Certification telephone number and pre-certify the admission.

2) If admission is not confirmed as being necessary, the administrator's physician will review the case with the employee's physician.

3) In an emergency, if the problem is life-threatening, you should be taken to the hospital, as pre-certification is not necessary. If admitted, the attending physician or hospital must notify the Certification Team within 48 hours.

4) If the employee does not have a non-emergency hospital admission pre-certified through the review program, the employee would pay 50% coinsurance up to a maximum penalty of $500.

5) To alleviate concerns about the application of an inappropriate copayment, the following will identify situations where the precertification penalty would not be applied:

(a) Emergency confinements where patient's condition precludes informing the hospital that certification is necessary (i.e., unconscious, severe accident, no identification).

(b) Employee presents Medical Plan Identification Card (which contains pre-cert toll free phone number) to hospital and hospital does not call to verify confinement.

(c) Employee advises his physician that pre-certification is necessary and the physician does not contact the Pre-Certification Center.

In situations b) and c), the copayment amount will be deducted from the payment made to the respective provider. In these situations, a letter will be sent to the provider advising them that their action caused a copayment. The employee must cooperate with the Company in situations such as described.

6) Substance Abuse and Mental Health Care Precertification (Network and Comprehensive Non-Network Medical Plans)

In order to be eligible for any benefit coverage for mental health or substance abuse conditions the employee (or a family member) **must call Value Options at 1-800-776-1224 prior to any treatment.**

Value Options will assist the employee (or member) in assessing the situation and ensuring quality care.

In case of emergency, requiring inpatient treatment, the employee (or family member) must contact Value Options within 24 hours of hospital admission to assure that treatment will be covered.

If Value Options is not contacted as specified, no benefits are available under this plan. If Value Options is contacted, but the employee (or member) elects not to use network benefits and follow Value Options's recommendations, they will be subject to a separate $400 deductible, and benefits will be reduced to 50%.

O. Summary Plan Descriptions

The Company agrees to provide each employee with a Summary Plan Description, describing the benefits and provisions of the Group Coverage.

P. Severe Delays in Claim Payments

Whenever payment of a claim covered by the Company's Group Benefit Plan has been unduly delayed through no fault of the employee, the Company or Administrator will take action to relieve the employee from harassment by a creditor or collection agency resulting from such delay.

Upon request from the employee, the Company or Administrator will notify the creditor or collection agency that the employee is covered by the Plan and that payment will be made in accordance with the terms of the Plan when the problem causing the delay has been resolved. A copy of the letter to such creditor or collection agency will be sent to the appropriate credit bureau in the area in which the employee resides.

Q. "Administrator"

The term "Administrator" as used in this Plan may mean the company, an insurance company, third party claims administrator or other intermediary selected by the Company to administer the program of benefits provided under the Plan.

LETTER OF UNDERSTANDING

Re: Temporary Disabilities

In the event an employee has medical approval to return to work with medical restrictions, such employee may be assigned to available work within the bargaining unit consistent with the medical restrictions. If the employee is not assigned to such work, the employee will be eligible, for Weekly Accident & Sickness Benefits.

For purposes of A&S, an employee shall be deemed to be disabled if he or she is under the care of a physician for such condition, and is unable to perform his or her normal occupation.

For the purposes of LTD, an employee shall be deemed to be disabled if he is under the care of a physician and is unable to peform work of the type performed at the plant where he has seniority.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Second Surgical Opinion
Active & Post-IPO Retirees (Not eligible for Medicare)

A. Second Surgical Opinion is available on a voluntary basis under the Company sponsored Case Network Plans and Comprehensive Non-Network Medical Plan for all surgical procedures.

B. If the second opinion does not confirm the first, then a third opinion is available.

If you elect to obtain a second opinion the second surgeon/specialist must be independent of the first surgeon and also be a board-certified specialist.

C. The Plan will consider the second and third opinion(s) and the tests related to obtain the opinion(s) as covered expenses under the Plan.

- If, after following the second (third) opinion procedures, the employee decides to proceed with the surgery, reimbursement will be covered under applicable Plan provisions.

International Union, UAW Case Corporation

LETTER OF UNDERSTANDING

Re: Vision Care Service Providers

During 1998 contract negotiations, the parties discussed participating providers for the vision care services currently provided under the Group Benefit Plan with a view toward maintaining quality service at a reduced cost to covered employees, retirees and their dependents.

The Company is prepared to investigate the use of Wisconsin Vision to provide services covered by the Plan for Wisconsin based employees and retirees. If it is found by mutual agreement of the Company and the Union that Wisconsin Vision offers high quality covered services on a cost neutral basis, the parties will work to replace VSP with Wisconsin Vision in areas where Wisconsin Vision operates.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: National and State Health Insurance Initiatives

This confirms our understanding that if, during the term of the 1998 Collective Bargaining Agreement, any Federal or State health security act is enacted or amended to provide hospital, surgical, medical, prescription drug, dental benefits, vision care, or hearing care for employees, retired employees, surviving spouses and dependents, which duplicate or may be integrated with the benefits of the Group Benefits Plan, then in such event, the benefits under the Group Benefits Plan will be modified so as to integrate or eliminate the duplication of such benefits with the benefits provided by such Federal or State law.

If any Federal or State health security act is enacted or amended as provided in the paragraph above, the Company will pay through the term of the 1998 Collective Bargaining Agreement any premiums, taxes or contributions employees may be required to pay under the law when they become effective, that are specifically earmarked or designated for the purpose of financing the program of benefits provided by law, and any savings realized by the Company from integrating or eliminating the duplication of benefits provided under the Group Benefits Plan with the benefits provided by law, shall be retained by the Company. If such tax on employees is based on wages, the Company will pay only the tax applicable to wages received from the Company.

This understanding is conditioned on the Company obtaining and maintaining such governmental approvals as may be required to permit the integration of the benefits under the Group Benefits Plan with the benefits provided by any such law.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Cost of Healthcare Coverage

During the 1998 contract negotiations the Company and the Union agreed that over the term of the 1998 labor agreement employees and retirees who are enrolled in a Company offered HMO, PPO or other plan will not have to pay any additional employee contributions above those which may be required for enrollment in the Case Network Plan (if any).

The Company will be responsible for the retention of HMOs, PPOs and other health care delivery mechanisms during the term of this agreement. In the event that any offered HMO or PPO does not continue to provide access and high quality, cost effective care on a sustaining basis to Case UAW members, the Company may exercise its right to terminate that provider, provided that a replacement plan is instituted that meets the requirements described below. The Company will give the Union at least ninety (90) days notice of its desire to replace a provider and the Company and Union will work together in the selection of the replacement plan. Any replacement plan will provide comparable benefits and access to the type of plan it replaces. If the replacement plan is an HMO or PPO it will satisfy the UAW's standards regarding access and quality for that type of plan.

The same principles will govern the selection of additional (as opposed to replacement) HMOs, PPOs or POS plans to be made available to Case UAW members.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Prepaid Group Dental Plans

The Company agrees to continue to offer Prepaid Group Dental Plans where available.

Employees will be offered the opportunity to enroll for the Prepaid Group Dental Plan once each year. Election to participate in the Prepaid Group Dental Plan shall be in lieu of participation in the existing Dental Care Plan of the Company. The Company and the Union agreed to explore the use of Dental Associates as a replacement for Dentacare for Wisconsin based employees. By mutual agreement the parties may offer the plan as described below.

In the event the premium of the Prepaid Group Dental Plan will be greater than the premium of the existing Dental Care Plan, employees shall make monthly premium payments equal to the amount by which the Prepaid Group Dental Plan premium is greater.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Annual Insurance Meeting

During the terms of this Agreement, the Company will schedule annual meetings at plant locations which will be attended by the Local Union Presidents, Bargaining Committee Chairmen, Local Union Insurance Representatives, and representatives of the Plant Human Resources Department and Corporate Benefits Department to review insurance claim administration if disputes are unresolved. At the request of the Company or the Union, a representative of the carrier will be in attendance at the meeting.

In addition, an annual meeting will be held at which one representative from the UAW Ag-Implement Department and one representative from the UAW Social Security Department and one insurance representative from each plant location will meet with the Company Benefits and Human Resources Management or their representatives, and representatives of the insurance carrier to discuss insurance plan administration.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Search and Save

The Union and the Company recognize that providers of health care could submit bills for services which are in error. If the bills are audited by the employee, an error found, and a corrected bill obtained and submitted by the employee, Case will pay the employee 50% of the savings between the original bill and the corrected bill up to $500.

To encourage the review of health care charges, the Union agrees to support Search and Save through communications to the local membership -- active employees and retirees.

The Company and Union will plan for the communication of and continuation of this Plan.

The Company will review the effectiveness of the program and report results to each local Union and the International Union on the payments made.

The continuation of the Search and Save Program will depend upon the success of the program for employees and Company. In any event, it will only be continued beyond the expiration of this contract by mutual agreement between the Company and the Union.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Wellness/Fitness Programs

The Union and the Company agree that helping to keep employees and their dependents healthy is a shared objective.

The Union and the Company agree to work together on specific wellness/fitness program including but not limited to: cancer detection, smoking cessation, weight loss, physical fitness, stress management and nutrition for active and retired employees and their dependents.

By encouraging employee, retiree, and dependent involvement, it is expected that in addition to physical well-being there is a potential for reduction in health care costs.

The specific programs will be designed by a joint Case/UAW task force and implemented based on local plant employee, dependent, and retiree needs.

Within 90 days following the ratification of the Agreement, representatives of the Company, Local Union, and International Representatives will meet to review and discuss preventive programs mentioned above.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Group Benefit Plan

Republic Service Bureau, Inc. (or as appropriate)

The patient, employee, or deceased named on the attached authorization is an employee of Case Corporation. It is understood that the patient, employee, or deceased is not financially responsible for additional expenses detected during your firm's review of the charges associated with the care or treatment provided to the patient, employee or deceased.

If you have any questions, please contact me at (___ ___-____).

Sincerely,

Human Resources Manager

Note: This letter will be signed by the local Human Resources Manager and attached to the authorization form the employee returns to the outside audit firm.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Claims Procedure and Insurance Meetings

During the 1998 Negotiations, the Company and Union discussed the procedure to be utilized to handle administrative issues and contested claims. The parties agree that the following understanding was reached.

A. Employees should use the informal procedure in each location to obtain answers to insurance matters.

B. If the employee does not get the matter resolved, a form for referring the matter should be submitted by the employee to the Local Insurance representative who will review the matter with the Plant Human Resource Manager or representative. If not resolved then it will be reviewed at the Plant meeting attended by a Corporate Benefits representative and a representative from UAW AG Impl. Department referred to in the Letter of Understanding - Annual Insurance Meetings.

C. If the matter is not resolved at that level, the matter will be brought before the National - Corporate Committee at mutually convenient times during the year.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Group Benefit Plan - "Total Control Account"

The Life Insurance Company's "Total Control Account" Money Market Option is available for handling proceeds in excess of $10,000 which are due beneficiaries from an insured plan.

The beneficiary(ies) are assisted in filing the claim through Case to the insurance company; when the claim has been processed, the beneficiary is advised, is provided confirmation of the account, and is given a personalized checkbook to write checks as needed.

This option is subject to it's availability from the life insurance carrier.

International Union, UAW

Case Corporation

LETTER OF UNDERSTANDING

Re: Physician Availability

During the 1998 contract negotiations, the parties discussed the appropriate benefit levels for participants in the CIGNA and Alliance Select PPOs. One intent of the PPO offering is to provide a broad spectrum of health care facilities and providers. In the event that either of the PPOs does not provide a particular medically required specialty within the area (which is part of the plan design) the plan participant's physician must notify the PPO of the need and if verifiable, the PPO is to refer participant to a non-network provider. The plan participant must receive a written referral. The benefits should be delivered at the in-network level. If a medically required provider is available within the PPO area but the member elects to use a provider who is not in the network, the charges will be paid, to the extent covered, on an out-of-network basis.

International Union, UAW

Case Corporation